STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155038	A. BUILDING 01 B. WING	09/13/2011

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
PARKVIEW NURSING CENTER	2200 WHITE RIVER BOULEVARD MUNCIE, IN47303

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PERCEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
K0000	A Life Safety Code Recertification and State Licensure Survey was conducted by the Indiana State Department of Health in accordance with 42 CFR 483.70(a). Survey Date: 09/13/11 Facility Number: 000013 Provider Number: 155038 AIM Number: 100266100 Surveyor: Phillip Komsiski, Life Safety Code Specialist At this Life Safety Code survey, Parkview Nursing Center was found not in compliance with Requirements for Participation in Medicare/Medicaid, 42 CFR Subpart 483.70(a), Life Safety from Fire, and the 2000 edition of the National Fire Protection Association (NFPA) 101, Life Safety Code (LSC), Chapter 19, Existing Health Care Occupancies and 410 IAC 16.2. This one story facility was determined to be of Type V (000) construction and was fully sprinklered. The facility has a fire alarm system with smoke detection in the corridors, spaces open to the corridors and battery smoke detectors in resident sleeping rooms. The facility has a	K0000		

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE | TITLE | (X6) DATE

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	capacity of 81 and had a census of 74 at the time of this survey. Quality Review by Robert Booher, Life Safety Code Specialist-Medical Surveyor on 09/20/11. The facility was found not in compliance with the aforementioned regulatory requirements as evidenced by the following:			
K0018 SS=E	Doors protecting corridor openings in other than required enclosures of vertical openings, exits, or hazardous areas are substantial doors, such as those constructed of 1¾ inch solid-bonded core wood, or capable of resisting fire for at least 20 minutes. Doors in sprinklered buildings are only required to resist the passage of smoke. There is no impediment to the closing of the doors. Doors are provided with a means suitable for keeping the door closed. Dutch doors meeting 19.3.6.3.6 are permitted. 19.3.6.3 Roller latches are prohibited by CMS regulations in all health care facilities. Based on observation and interview, the facility failed to ensure 1 of 10 resident room corridor doors on 300 hall and 1 of 2 linen room corridor doors on 200 hall would latch into their frame. This deficient practice could affect 19 residents on 300 hall and 40 residents on 200 hall as well as visitors and staff.	K0018	The door to room 311 was repaired so it will latch, The linen storage door on the West Side was repaired to allow it to come to a complete latch. No resident was affected by the doors operation. Resident rooms and service area doors were inspected to ensure the proper closure of each door was operational. Resident Room and service area	10/13/2011

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	Findings include: Based on observations on 09/13/11 between 1:00 p.m. to 2:35 p.m. with the Maintenance Supervisor, the doors leading into resident room number 311 and the linen room on 200 hall did not latch into their frame. Based on interview on 09/13/11 concurrent with each observation with the Maintenance Supervisor, it was acknowledged the aforementioned doors would not latch into their frame. 3.1-19(b)		doors will be inspected weekly to ensure the proper latch closure is operating correctly. Any door that is not operating correctly will be repaired for proper closure. Weekly inspections of the doors will be completed and reported to the QA committee at its regular monthly meeting.	
K0021 SS=E	Any door in an exit passageway, stairway enclosure, horizontal exit, smoke barrier or hazardous area enclosure is held open only by devices arranged to automatically close all such doors by zone or throughout the facility upon activation of: a) the required manual fire alarm system; b) local smoke detectors designed to detect smoke passing through the opening or a required smoke detection system; and c) the automatic sprinkler system, if installed. 19.2.2.2.6, 7.2.1.8.2 Based on observation and interview, the facility failed to ensure 1 of 8 sets of	K0021	The smoke barrier door near the East Nurses Station was repaired to allow	10/13/2011

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	smoke barrier doors was held open by a device which allows the doors to close upon activation of the fire alarm system. This deficient practice could affect 9 residents on 300 hall next to the nurse's station as well as visitors and staff. Findings include: Based on observation on 09/13/11 at 2:55 p.m. with the Maintenance Supervisor, the set of smoke barrier doors leading into 300 hall next to the nurse's station would not release from its magnetic hold-open during a fire alarm test. Based on interview on 09/13/11 at 02:59 p.m. with the Maintenance Supervisor, it was acknowledged the 300 hall set of smoke barrier doors would not release from it's magnetic hold-open and close. 3.1-19(b)		it to close automatically when the door is released for close during fire emergencies. No residents were affected by this doors operation. The fire doors will be inspected weekly for proper closure and operation. Any door that is not operating correctly will be repaired for proper closure. Weekly inspections of the fire doors will be completed and reported to the QA committee at its regular monthly meeting.	
K0038 SS=E	Exit access is arranged so that exits are readily accessible at all times in accordance with section 7.1. 19.2.1 Based on observation and interview, the facility failed to ensure exit access discharge was arranged so 3 of 12 exits were readily accessible at all times. Exit access as a means of egress must be free	K0038	The bench was removed immediately from the path of egress from the main Dining Room Exit. No residents were affected by this practice. Daily inspections will be completed	10/13/2011

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	of obstructions which would prevent its use. This deficient practice could affect 12 residents observed in the dining room who would use the adjacent set of doors as an exit as well as visitors and staff if the facility were required to evacuate. Findings include: Based on observation on 09/13/11 at 12:15 p.m. with the Maintenance Supervisor, the exit discharge leading out of Main dining room on the south end of the building was blocked with two four foot benches which were placed in front of, and outside of, the exit doors used to exit the main dining room. Based on interview on 09/13/11 concurrent with the observation with the Maintenance Supervisor, it was acknowledged the aforementioned exit discharge was blocked by two benches on the outside which were provided for residents, visitors and staff. 3.1-19(b)		to ensure the proper placement of furniture on the front porch are not blocking the egress from the exit doors. Weekly inspections of the doors will be completed and reported to the QA committee at its regular monthly meeting.	
K0046 SS=F	Emergency lighting of at least 1½ hour duration is provided in accordance with 7.9. 19.2.9.1. Based on observation and interview, the	K0046	The lighting was repaired at each exit to ensure it will illuminate in case of	10/13/2011

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	facility failed to ensure 12 of 12 exits were provided with emergency powered illumination. LSC 7.9.1 says the exit discharge shall include only designated stairs, aisles, walkways leading to a public way. LSC 7-9.2 requires emergency lighting shall be provided for not less than 1 1/2 hours arranged to provide not less than an average of 1 foot candle,and at any point not less than 0.1 foot candles, measured along the path of egress at floor level. This deficient practice could affect all residents as well as visitors and staff evacuating the facility during a power outage at night. Findings include: Based on observation on 09/13/11 at 3:39 p.m. with the Maintenance Supervisor during a test of the emergency generator, none of the outside lights which were supposed to illuminate during a load test were active. Based on interview on 9/13/11 at 3:41 p.m. with the Maintenance Supervisor, it was confirmed the exit lights and exit discharge lights would not illuminate during a generator load test. 3.1-19(b)		power failure. No residents were affected by this practice. Weekly inspections of the lighting for all exits will be conducted and if found to be not functioning will be repaired. Weekly inspections of the exterior lighting will be completed and reported to the QA committee at its regular monthly meeting.	

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K0051 SS=F	A fire alarm system with approved components, devices or equipment is installed according to NFPA 72, National Fire Alarm Code, to provide effective warning of fire in any part of the building. Activation of the complete fire alarm system is by manual fire alarm initiation, automatic detection or extinguishing system operation. Pull stations in patient sleeping areas may be omitted provided that manual pull stations are within 200 feet of nurse's stations. Pull stations are located in the path of egress. Electronic or written records of tests are available. A reliable second source of power is provided. Fire alarm systems are maintained in accordance with NFPA 72 and records of maintenance are kept readily available. There is remote annunciation of the fire alarm system to an approved central station. 19.3.4, 9.6 1. Based on observation and interview, the facility failed to maintain 2 of 2 fire alarm systems in accordance with NFPA 72, 1999 Edition, National Fire Alarm Code. NFPA 72, 1-5.4.4 requires fire alarms, supervisory signals, and trouble signals to be distinctive and descriptively annunciated. NFPA 72, 3-8.1 allows fire alarm system components to share control equipment or operate as stand alone systems, but in any case, they shall be arranged to function as a single system. This deficient practice could affect all residents as well as visitors and staff. Findings include:	K0051	The autodialer was serviced by the vendor immediately. The autodialer was powered down and reset, unplugged and retested. During retest the autodialer functioned as required. The annuciation was correctly identified on the panel signal on the fire alarm system to alert staff when the system was in a trouble status. The message that is displayed on the fire panel was changed to denote the actual trouble so staff responding will be alerted to the exact problem. An automatic smoke detector has been installed in the room where the fire panel is located and tested in accordance to the policy and procedure. No residents were affected by this practice. Weekly inspections of the of the fire	10/13/2011

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	Based on observation with the Maintenance Supervisor on 9/13/11 at 3:15 p.m., when the fire alarm system was placed into trouble when a phone line from the dialer was disconnected, a visual trouble signal on the dialer was activated and transmitted to the dialer below the fire alarm control panel (FACP) located at the nurses' station on 300 hall. An audible signal was emitted but the panel indicated "Low pressure" instead of phone line trouble. Based on interview on 9/13/11 at 3:17 p.m. with a representative from the monitoring company, it was acknowledged an audible signal did sound, but the message conveyed by the FACP indicated "Low pressure" instead of phone line trouble. 3.1-19(b) 2. Based on observation and interview, the facility failed to ensure 1 of 2 fire alarm control panels (FACP), located in an area which was not continuously occupied, was provided with automatic smoke detection to ensure notification of a fire at that location before it is incapacitated by fire. LSC 9.6.2.10 refers to NFPA 72, the National Fire Alarm Code. NFPA 72 at 1-5.6 requires an automatic smoke detector be provided at the location of each fire alarm control unit which is not located in an area		panel will be completed and tests of the emergency system will be completed for one month then monthly. Weekly inspections of the fire panel will be completed for 4 weeks then monthly and reported to the QA committee at its regular monthly meeting.	

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	continuously occupied to provide notification of a fire in that location. This deficient practice could affect all residents on 200 hall west and the Therapy room as well as visitors and staff. Findings include: Based on observation on 09/13/11 at 1:45 p.m. with the Maintenance Supervisor, the FACP located in the north closet of the Therapy room which is locked and inaccessible after 5:30 p.m. was not provided with a smoke detector to alert staff elsewhere in the facility of smoke or fire in the area. Based on interview on 09/13/11 at 1:47 p.m. with the Maintenance Supervisor, it was acknowledged the FACP in the Therapy room closet was not provided with smoke alarm protection. 3.1-19(b) 3. Based on observation and interview, the facility failed to ensure the 1 of 2 fire alarm activations would automatically transmit a signal to a central monitoring station. LSC 9.6.4 requires the fire alarm system shall be arranged to automatically transmit the fire alarm signal to an Auxiliary alarm system, Central station, Proprietary system or Remote station connection. This deficient practice could			

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	affect all residents as well as visitors and staff. Findings include: Based on observation on 09/13/11 at 3:03 p.m. with the Maintenance Supervisor, when the fire alarm was activated the signal which was to be transmitted to the Central monitoring station was not received. A second fire alarm test was conducted at 3:20 p.m. with a representative from a fire alarm maintenance company and this time the transmitted signal was received. Based on interview on 09/13/11 concurrent with the second alarm test with the fire alarm representative, it was acknowledged the reason for the failure of the first test to transmit a signal was unknown and required further investigation. 3.1-19(b)			

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K0066 SS=E	Smoking regulations are adopted and include no less than the following provisions: (1) Smoking is prohibited in any room, ward, or compartment where flammable liquids, combustible gases, or oxygen is used or stored and in any other hazardous location, and such area is posted with signs that read NO SMOKING or with the international symbol for no smoking. (2) Smoking by patients classified as not responsible is prohibited, except when under direct supervision. (3) Ashtrays of noncombustible material and safe design are provided in all areas where smoking is permitted. (4) Metal containers with self-closing cover devices into which ashtrays can be emptied are readily available to all areas where smoking is permitted. 19.7.4 Based on observation, record review and interview; the facility failed to ensure 1 of 1 areas where smoking was permitted was provided with a metal container with a self closing cover where cigarette butts could be extinguished. This deficient practice could affect 7 residents observed in the Dining room as well as visitors and staff near the upper Dining room smoking area outside Main hall. Findings include: Based on observation on 09/13/11 between 12:01 p.m. and 3:00 p.m. with	K0066	The staff smoking area was immediately moved and the area was cleaned up of any debris and cigarette butts. The metal ashtrays were placed for the residents use. All of the plastic containers were removed immediately. The ground outside the 300 hall, and the southeast exit was cleaned and all the debris and cigarette butts were removed. The non combustible containers were removed immediately. The smoking policy was reviewed with the residents and staff were inserviced. No residents were affected by this practice. Daily inspection of the smoking area	10/13/2011

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	the Maintenance Supervisor, the smoking area on the front porch just outside the front entrance used plastic Maxwell house containers to empty ash and deposit cigarette butts. Further observation revealed over one hundred cigarette butts were counted on the ground outside 300 hall within twenty feet of the emergency generator. In addition, an employee was observed flicking a lit cigarette on to the ground prior to entering the facility at the southeast exit. Based on record review on 09/13/11 at 3:45 p.m. the smoking policy indicated cigarettes would be deposited into a noncombustible container. The smoking policy also indicated only the front porch next to the Main dining room could be used as a smoking area. Based on interview on 09/13/11 concurrent with each observation, it was acknowledged by the Maintenance Supervisor smoking was allowed to occur in areas other than the front porch and plastic containers were used to deposit cigarette butts. 3.1-19(b)		will be completed and any concerns will be reported immediately for re-education of staff and residents. Reports of smoking adherence will be completed 5 times per week at its Daily Standup Meeting and reviewed by the QA committee at its monthly meeting.	
K0130 SS=E	OTHER LSC DEFICIENCY NOT ON 2786			

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	Based on observation, interview and record review; the facility failed to ensure the location of 1 of 1 liquefied petroleum gas (LPG) containers was at least 5 feet away from a designated smoking area. LSC 8.4.3.1(3) requires the storage and handling of flammable liquids or gases to be in accordance with NFPA 58, 1998 Edition Liquefied Petroleum Gas Code. NFPA 58, Section 3-2.2.2 requires containers installed outside of buildings to be in accordance with Table 3-2.2.2. and Section 3-2.2.2(d) specifies the distance measured in any direction from the point of discharge of a container pressure relief valve, the vent of a fixed maximum liquid level gauge on a container, or the installed location of the filling connection of a container to any exterior source of ignition, openings into direct-vent (sealed combustion system) appliances, or mechanical ventilation air intakes shall be in accordance with Table 3-2.2.2(d). Table 3-2.2.2(d) indicates the minimum distance between a portable LPG container replaced on a cylinder exchange basis and an exterior ignition source is 5 feet. This deficient practice could affect any resident near the smoking area including staff or visitors using the smoking area outside the facility near the south patio. Findings include:	K0130	The staff smoking area was immediately moved to a safe location which is more than 5 feet away from the liquefied petroleum gas tank. Identified smoking areas for residents and staff were identified on the smoking policy. No residents were affected by this practice. Daily inspection of the smoking area will be completed and any concerns will be reported immediately for re-education of staff and residents. Reports of smoking adherence will be completed 5 times per week at its Daily Standup Meeting and reviewed by the QA committee at its monthly meeting.	10/13/2011

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	Based on observation on 09/13/11 at 1:15 p.m. with the Maintenance Supervisor, the five hundred gallon propane tank used to power the generator was five feet from an area where ten cigarette butts were found on the ground. Based on interview on 09/13/11 at 1:20 p.m. with the Maintenance Supervisor, it was acknowledged this area has been used as a place to smoke though it is regarded as a nonsmoking area. Furthermore, the Maintenance Supervisor was unaware the propane tank needed to be five feet away from an ignition source. Based on review of the smoking policy on 09/13/11 at 3:45 p.m., the only smoking area allowed around the faciilty is the front exit on the south part of the building adjacent to the main dining room. 3.1-19(b)			
K0144 SS=F	Generators are inspected weekly and exercised under load for 30 minutes per month in accordance with NFPA 99. 3.4.4.1. 1. Based on observation, record review and interview; the facility failed to ensure 1 of 1 emergency generators was equipped with a remote manual stop. LSC 7.9.2.3 requires emergency generators providing	K0144	A remote manual shutoff has been ordered to be installed for the generator. No residents were affected by this practice. Monthly testing will be conducted to	10/13/2011

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	power to emergency lighting systems shall be installed, tested and maintained in accordance with NFPA 110, Standard for Emergency and Standby Power Systems. NFPA 110, 1999 edition, 3-5.5.6 requires Level II installations shall have a remote manual stop station of a type similar to a break-glass station located elsewhere on the premises where the prime mover is located outside the building. NFPA 37, Standard for the Installation and Use of Stationary Combustion Engines and Gas Turbines, 1998 Edition, at 8-2.2(c) requires engines of 100 horsepower or more have provision for the shutting down the engine at the engine and from a remote location. This deficient practice could affect all occupants. Findings include: Based on observation of generator equipment on 09/13/11 at 2:45 p.m. with the Maintenance Supervisor, evidence of a remote shut off device was not found for the generator. Based on review of Generator Maintenance records on 09/13/11 at 3:30 p.m. with the Maintenance Supervisor, it was revealed the generator was installed in 2005 and a remote means to shut the generator off was not provided. Based on interview on 09/13/11 at 2:48 p.m. with the Maintenance Supervisor, it was		ensure the generator is operational. Tests will be completed once a month and reported to the QA committee at its regular monthly meeting to ensure the tests have been completed and the operation of the generator was properly functioning.	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155038	A. BUILDING 01 B. WING	09/13/2011

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	acknowledged the facility was aware a remote shut off for the generator was required, but had not yet installed one. 3.1-19(b) 2. Based on record review and interview, the facility failed to ensure a monthly load test for 1 of 1 emergency generators was conducted using one of the three following methods: under operating temperature conditions, at not less than 30% of the Emergency Power Supply (EPS) nameplate rating, or loading that maintains the minimum exhaust gas temperatures as recommended by the manufacturer. Chapter 3-4.4.1.1 of NFPA 99 requires monthly testing of generators serving the emergency electrical system to be in accordance with NFPA 110. Chapter 6-4.2 of NFPA 110 requires generator sets in Level 1 and Level 2 service to be exercised at least once monthly, for a minimum of 30 minutes, using one of the following methods: a. Under operating temperature conditions or at not less than 30 percent of the EPS nameplate rating. b. Loading that maintains the minimum exhaust gas temperatures as recommended by the manufacturer. The date and time of day for required testing shall be decided by the owner, based on facility operations. This			

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	deficient practice could affect all residents, staff and visitors. Findings include: Based on review of Generator System Testing records and Maintenance logs on 09/13/11 at 3:38 p.m. with the Maintenance Supervisor, there was no documentation which verified the the amperage or the percentage of load capacity for the past twelve months. Based on interview on 09/13/11 at 3:40 p.m. with the Maintenance Supervisor, it was acknowledged the facility had no documentation to verify amperage or percentage of load capacity for the generator for the past twelve months. 3.1-19(b)			